Focus Group on Essential Components for State HAI Efforts: Meeting Summary

September 14, 2011
Dallas/Fort Worth, TX

Organized by:
Office of Healthcare Quality
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services

INTRODUCTION & BACKGROUND

On Wednesday, September 14, 2011 the U.S Department of Health & Human Services (HHS), Office of the Assistant Secretary for Health (OASH), Office of Healthcare Quality (OHQ) held the "Focus Group on Essential Components of State Healthcare-Associated Infections (HAI) Efforts" in Dallas/Fort Worth, TX. The purpose of the half-day focus group was to identify, prioritize, and designate lead stakeholders and required resources that are essential components of a state-level HAI prevention program.

The focus group consisted of representatives from the federal government, including the Department of Defense (DoD), HHS[1], and the Veterans Administration (VA). Non-federal participants included representatives from the American Hospital Association (AHA), the Association for Professionals in Infection Control and Epidemiology (APIC), the Association of State and Territorial Health Officials (ASTHO), Blue Cross & Blue Shield of Texas, Consumers Union, the Council of State and Territorial Epidemiologists (CSTE); the Infectious Disease Society of America (IDSA), the Joint Commission (JC), the National Association of County and City Health Officials (NACCHO), the Society for Critical Care Medicine, and the Society for Healthcare Epidemiology of America (SHEA). Delegations from two states (Michigan and South Carolina) with mature HAI programs also participated. The focus group was facilitated by Rachel Stricof, MPH, CIC and Katherine Kahn, MD.

OPENING & PRESENTATIONS BY THE STATES

Don Wright, MD, MPH, the HHS Deputy Assistant Secretary for Healthcare Quality, opened the meeting by defining the objectives and potential starting points for the focus group. To aid group efforts to identify and prioritize essential thematic components of a state HAI prevention program, Dr. Wright defined essential *thematic components* as those without which states would not have the baseline capability to reduce HAI incidence. Dr. Wright noted that, whereas efforts to prevent and reduce HAIs have progressed considerably during recent years, much work remains to be accomplished. He asked focus group participants to keep in mind that all states are not at the same level of maturity and that there is no "one size fits all approach" to HAI prevention.

Michigan and South Carolina were chosen for their experience in HAI prevention and the different paths they followed to achieve stable and successful programs. Michigan has no HAI reporting mandate and the HAI program was initiated by the state hospital association; South Carolina has a legislated reporting mandate and its prevention program is led by the state department of health. Both states provided brief background on their programs and identified components that they found to be essential in building them.

South Carolina found legislation helpful in starting the process, as was the legislatively mandated advisory council that allowed for collaboration. Since its passing, the legislation has been amended two times to accommodate lessons learned. South Carolina also noted the usefulness of CDC's National Healthcare Safety Network, as it is free to use and eliminates the need to build a system from the ground up.

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[1] Including representation from: the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), HHS Region VI and Region VIII offices, and OHQ

Michigan's program developed from the Michigan Hospital Association's board of trustees identifying the need to help member hospitals work toward a higher level of quality and a safer level of care delivery. The hospital association collaborated with the state Quality Improvement Organization (QIO), state health department, medical societies and payers, and implemented the Comprehensive Unit-Based Safety Program (CUSP; www.onthecuspstophai.org) to prevent central-line associated bloodstream infections (CLABSIs). Along with this program, Michigan identified the integrating of the people with the elements of each process as a component of success. Today the Michigan HAI Program is co-led through a public-private partnership between the state health department, hospital association, and quality improvement organization. The Michigan HAI Prevention Advisory Group was established and coordinated by the state health department. The health department collects HAI data and develops reports from facilities voluntarily sharing data via NHSN (~50% of acute care facilities participating to date). The hospital association continues to lead the majority of state prevention initiatives.

IDENTIFYING ESSENTIAL THEMATIC COMPONENTS

A list of potential essential components (Appendix A) was presented and participants were asked if they thought that any of the components listed was not essential, or if any component not listed was essential. Overall, the participants agreed with the list. There was some discussion surrounding those components that are not in the state domain, for example, data collection accomplished at the national level through NHSN. Participants noted that, although NHSN is a federal tool, states can utilize it as part of their program to see data across the state. There was also discussion surrounding the harmonization of data collection and the burden of data reporting on front-line staff. Cultural elements were discussed for some time, including the idea that mandated reporting should not be used in such a way as to be seen as punitive, which could reduce trust and complicate efforts to aid sites or healthcare facilities with high HAI rates. Participants agreed that the culture of a state HAI program should be one of transparency and ownership.

DETERMINING PRIORITY COMPONENTS

Through discussion, the participants edited, but did not remove, any of the original eight components. They added an additional five components: legislation; transparency; culture of health, safety and learning; evidence of effective practice; and HAI prevention across the healthcare spectrum (Appendix A). The participants were then asked to identify their top eight priority components. Those components that the participants deemed to be top priority were discussed in regard to which stakeholder was best suited to take the lead and which resources were required.

Below are the top five priority components, the identified potential leads, a summary of the discussion surrounding the potential leads, the proposed required resources and a summary of the discussion of the proposed required resources.

PRIORITY ORDER ONE:

Coordination, collaboration, and integration (26 votes total)

First priority (16 votes); Second priority (9); Third priority (1)

LEAD:

- **State department of health**
- **State hospital association**
- **Healthcare facilities** (all sizes, teaching/nonteaching, rural, urban)

The convener of this component should be an independent public entity that has public trust and is accountable to the public (like the health department). Having a regulatory body convening and setting up may help. When reporting is mandated, legislation and regulations can identify the convener. In the absence of a legislated mandate, states may have more flexibility. Depending on the specific issue, the stakeholder who takes the lead might change. This component may be bigger than one agency and may be a role for the multidisciplinary advisory committees that have been formed in each state.

REQUIRED RESOURCES:

Personnel: Someone whose full job is to maintain a relationship with partners potentially as a leader or manager. For data analysis and technical knowledge, an epidemiologist and/or an Infection Preventionist would be required. Information Technology, logistical and operations support (i.e., a person to take minutes, etc.) would also be required.

Communications and interaction: A communication vehicle or mechanism is a key element of this component. A communication platform where the stakeholders can share information openly will be needed. There will need to be a way to bring people together (requiring financial resources), allowing participation by phone/public monitoring of meetings by phone.

Organization: Project management and an agreed-upon "rules of the road" will be a key element of the component; it would be helpful to have a model (e.g., multidisciplinary advisory group charter). New Partnership for Patients Hospital Engagement Contracts represent a potential resource; federal money will come through this mechanism.

PRIORITY ORDER TWO:

Data and monitoring (25 votes total)

First priority (8 votes); Second priority (12); Third priority (3); Fourth priority (1); Seventh priority (1)

LEAD:

- **State health department** (in some cases this responsibility could be contracted out)
- **Hospital association *and* state health department**
- **QIOs** (already do validation, could also be a convener for data collection at non-regulated facilities)

States need a competent, independent, disinterested government body for data validation. Having state government play the role of validator and auditor may lead to better results. For surveillance and data, it's essential to have an organization that represents the entire state, not just a subgroup. The lead needs to be able to ensure the interests of the entire state are represented. It's vital to look at the potential for unintended consequences. If the measurement is intensive care unit (ICU) mortality, a hospital can game the system if they transfer the patient out of the ICU. Make sure what's measured is what matters in the process. Who can act on the data should influence who takes the lead.

REQUIRED RESOURCES:

Technical resources: Making sure NHSN is well supported and can handle traffic demands, including the reporting of more real-time data. For timely data beyond NHSN, there may be a need to build systems at the state level. Building infrastructure for infection preventionists to continue to do their work is a priority. SAS or other statistical capability will be required for analysis. Electronic data capture may help maximize reporting from hospitals. Synchronization with the national programs to incentivize the adoption of electronic health records (EHR). Remote services or telemedicine resources will be needed for rural areas.

Reporting: Data should be able to be utilized across the continuum of care. States will need data validation methodology. States can provide additional data on risk factors. A lighter data collection burden should be kept in mind as states don't want an unfunded mandate.

Guidance: There should be federal guidance for data quality expectations. HHS has a crucial role in establishing standards for data collection. CDC can provide education on how to ensure data quality.

Personnel: A full-time infection preventionist and travel money (the number of preventionists would depend on the number of facilities in the state and other factors). Workforce development: in some cases, hospitals will want to recruit infection preventionists, but there are currently not enough available. An epidemiologist for data analysis. Small (5-7 bed) hospitals and other facilities will not have an epidemiologist or even an Infection Preventionist a situation that may call for use of centralized resources. Clinical pharmacists may provide a centralized stable resource for smaller hospitals.

PRIORITY ORDER THREE:

Implementation Disemination Evaluation Assessment (IDEA) (28 votes total)

Second priority (5 votes); Third priority (17); Fourth priority (2); Fifth priority (2); Eighth priority (2)

LEAD:

- **Professional societies (e.g., SHEA, APIC)**
- **An investigative champion/the academic community**
- **A competent state hospital association**

REQUIRED RESOURCES:

Personnel: This will require boots/staffing on the ground. People who work directly with teams in hospitals to help with implementation can identify what is missing. People who can do training might donate their time and expertise. Some advocates are doing trainings in nursing and medical schools; this enhances education and training. People providing environmental services such as housekeeping are key to success.

Training: While waiting for enough boots or personnel, states will need to train those staff currently in place, in addition turnover of infection preventionists is currently high in many states. The *Partnering to Heal: Teaming Up Against Healthcare-Associated Infections* on-line training should be recommended in medical and nursing schools and hospitals. The federal government could help facilitate other resources similar to *Partnering to Heal*. Training of community leaders should also take place, as they have good knowledge of the cultures they're working in. Resources should be committed locally and adapted to the local needs.

Mentoring: A hospital with a well-developed program can train those that don't have developed programs.

Institutional organizations: Most institutions are not independent but belong to a larger organization or system. Training can be exported from the parent organization to the local level.

Communication: The ability to communicate to all groups involved need to be an available resource.

Trust: With trust, people will tell each other of existing barriers; states need technical and logistical support for this.

PRIORITY ORDER FOUR:

Regulations, quality assurance, and legislation (14 votes total)

First priority (2 votes); Third priority (1); Fourth priority (3); Fifth priority (3); Sixth priority (2); Seventh priority (1); Eighth priority (2)

LEAD:

The leads for regulations and for legislation should be different.

- **State health department (regulations)**
- **Multidisciplinary advisory group**

The convener group has the responsibility for creating the right environment so infection prevention can succeed. In North Carolina, a mandate was translated into legislation through a health commission. In Tennessee, input on legislation, rules, and regulations was provided by an advisory committee. All states currently have multidisciplinary advisory groups for state-level action plans; states should build on what exists already.

REQUIRED RESOURCES:

Troubleshooting: States need resources to follow up with when problems are identified.

Models: The ambulatory surgery approach for surveying was developed collaboratively and is a good example. APIC, IDSA and SHEA have put out papers on model legislation. A list of pertinent elements and other guidance for writing legislation is needed. It would be helpful to have examples of good language for legislation, interpretive guidelines, and regulations. Consider creating a library of resources for improvements (toolkits, etc.). To develop sound regulations and get rid of obsolete ones, states might need to develop things not out there yet.

Communication: In some states, cited institutions are posted online. It's important to have resources to communicate to the public what is happening.

Infection disclosure acts provide powerful self-regulation. Regulations that require transparency are at the core of ensuring qualityassurance. Regulations should be procedure-specific, not facility-specific.

PRIORITY ORDER FIVE:

Culture of safety, health, and learning (19 votes total)

Fourth priority (6 votes); Fifth priority (4); Sixth priority (5); Seventh priority (3); Eighth priority (2)

LEAD:

- **A multidisciplinary advisory group with representation from across the state**
- **State department of health**
- **State hospital association**

REQUIRED RESOURCES:

Technical: A comparative database to compare cultural standards from one institution to another. AHRQ currently has a metric for measuring culture, which could help to know if culture is changing. The development of a well-defined and robust adverse event reporting system to help teach from past lessons learned. This system would also ensure that near misses are not covered up or omitted. Many hospitals don't have a sound reporting system that is not punitive.

Content: An intervention set that is standards-based. Technical expertise is an important resource; how to improve (an adaptive process) draws on a different skill set than training.

Engagement: Buy-in of hospital leadership; hospital associations are crucial in this. Marketing campaigns, to make sure what you're doing gets out there. Rewards for improving culture to highlight gains.

NEXT STEPS

The background and reasoning for the focus group was presented to approximately 300 attendees during the "State-Level Partners Collaborating to Eliminate Healthcare-Associated Infections" meeting held on September 15-16 in Dallas/Fort Worth, TX. Attendees voted on the priority essential components through an audience response system, results of which agreed with three of the top four priority essential components as identified and ranked by the focus group participants. The attendees at the State-Level Partners meeting found a culture of safety, health and learning to be their third priority component.

Next steps include advocating for further work to define and establish an evidence base for the listed components. As there was much discussion within the focus group surrounding data collection, validation, and reporting, OHQ plans to contin

ue this disucssion at the upcomming "HAI Data Summit" co-hosted by OHQ and the Office of the National Coordinator on Health IT in spring 2012. OHQ also will be compling a report idenfitying the work which has been completed by each state and highlighting how this work fullfills many of the identified essental componets.

APPENDIX A

IDENTIFIED ESSENTAL COMPONENTS OF A STATE HEALTHCARE-ASSOCIATED INFECTIONS EFFORT*

Coordination ~~and stakeholder engagement~~, collaboration, and integration
Data and monitoring
Outbreak investigation
~~Education and Training/Dissemination~~ Implementation, Dissemination, Evaluation, Assessment (IDEA)
Evaluation
Legislation, regulations, and quality assurance
Reimbursement strategies
Advocacy
Legislation
Transparency
Culture of health, safety, and learning
Evidence of effective practice
HAI across the healthcare spectrum

*Essental components listed in black were provided to the focus group as a starting point of discussion;essential components listed in red were added by the focus group participants and those with strikethroughs were edited by the focus group participants.